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IN THE COURT OF APPEALS OF NORTH CAROLINA

No. COA16-1154

Filed: 15 August 2017

Forsyth County, No. 14 CVS 4177

JUDITH BARBEE and THOMAS BARBEE, Co-Administrators of the Estate of
LAUREN BARBEE, Plaintiffs,

v.

WHAP, P.A. and LYNDHURST GYNECOLOGIC ASSOCIATES, P.A., Defendants.

Appeal by plaintiffs from orders entered 18 March 2016 and 13 May 2016 by
Judge R. Stuart Albright in Forsyth County Superior Court. Heard in the Court of
Appeals 18 April 2017.

*Law Offices of Michael Eldredge, by Michael Eldredge, for plaintiffs-
appellants.*

*Wilson & Helms LLP, by Linda L. Helms and Lorin J. Lapidus, for defendants-
appellees.*

DAVIS, Judge.

Judith Barbee and Thomas Barbee (collectively “Plaintiffs”) appeal from the
trial court’s order granting the motion for summary judgment of WHAP, P.A. and
Lyndhurst Gynecologic Associates, P.A. (collectively “Defendants”). After careful
review, we affirm.

Factual and Procedural Background¹

Plaintiffs are the parents and co-administrators of the estate of the decedent, Lauren Barbee (“Barbee”). In 2012, Barbee learned that she was pregnant with her first child. On 6 March 2012, she became a patient of Lyndhurst Gynecologic Associates, P.A. (“Lyndhurst”). Lyndhurst is a member of the Women’s Health Alliance of the Piedmont, P.A. (“WHAP”), which is “an alliance of practitioners providing obstetrical care to patients in Forsyth County, North Carolina.” Among Lyndhurst’s employees are five obstetricians who were involved in Barbee’s treatment prior to her death: Dr. Amber Hatch, Dr. W. Michael Lindel, Dr. Stacey Sheets, Dr. R. Lamar Parker, and Dr. Brad Jacobs (collectively the “Lyndhurst Physicians”).

During Barbee’s prenatal care, the Lyndhurst Physicians diagnosed her with lupus, an autoimmune disease. On 27 August 2012, Barbee was in the third trimester of her pregnancy and was seen at Lyndhurst for complaints of cramping. One of the Lyndhurst Physicians determined that her blood pressure was elevated and that she had protein in her urine. The next day, Barbee was sent to Forsyth Medical Center for further evaluation for possible preeclampsia.²

¹ Because this case involves a number of complex medical terms, we provide definitions of those terms where appropriate.

² Preeclampsia is defined as “a toxic condition developing in late pregnancy characterized by a sudden rise in blood pressure, excessive gain in weight, generalized edema, albuminuria, severe

On 28 August 2012, Barbee was admitted to Forsyth Medical Center for a preeclampsia evaluation. Dr. Hatch evaluated Barbee and ordered a urinalysis and complete blood count. The results from these tests showed that Barbee was “experiencing severe thrombocytopenia³ with a platelet count at a critically low level of 29,000 per microliter, hemolysis, and elevated lactate dehydrogenase.” (Footnote added.) Based on these results, Dr. Hatch ordered a platelet transfusion and a round of steroids for treatment of the thrombocytopenia. Dr. Hatch also noted that “she was unsure of [the] cause of thrombocytopenia and that a consultation with a maternal-fetal medicine (MFM) physician⁴ and hematologist should be considered.” (Footnote added.)

On 29 August 2012, Dr. Hatch consulted with Dr. Lindel, and the two physicians “agreed that they should induce labor and deliver Barbee’s child upon the stabilization of [her] platelets.” At 2:47 a.m. on 30 August 2012, Barbee gave birth to a son by vaginal delivery without any complications. At approximately 11:00 a.m.

headache, and visual disturbances[.]” Webster’s Third New International Dictionary 1787 (1966) (hereinafter “Webster’s International Dictionary”).

³ Thrombocytopenia is defined as a “persistent decrease in the number of blood platelets that is usually associated with hemorrhagic conditions.” Webster’s Ninth New Collegiate Dictionary 1230 (1991).

⁴ Maternal-fetal medicine physicians (“MFM physicians”) are “high-risk pregnancy experts, specializing in the un-routine.” *What is a Maternal-Fetal Medicine Specialist?*, Society for Maternal-Fetal Medicine, available at <https://www.smfm.org/members/what-is-a-mfm>.

that morning, Dr. Sheets took over the treatment and care of Barbee. She diagnosed Barbee with HELLP syndrome⁵ and ordered a transfusion of packed red blood cells.⁶

At 11:30 p.m. on 30 August 2012, the nurse monitoring Barbee informed Dr. Sheets that Barbee's blood pressure was elevated. On 31 August 2012, Dr. Parker ordered a transfusion of two units of platelets.

On 1 September 2012, after determining that her platelet count was severely low, Dr. Jacobs ordered another transfusion of packed red blood cells and platelets. Later that afternoon, Dr. Jacobs was informed that Barbee's platelets were once again at a critically low level. The following day, Dr. Jacobs evaluated Barbee and noted that "thrombocytopenia [was] still an issue" and that her medical course "was not acting like normal HELLP." At 8:20 a.m., Dr. Jacobs decided to consult a hematologist and an MFM physician.

Dr. Joshua F. Nitsche, an MFM physician, evaluated Barbee at 11:30 a.m. that same day and diagnosed her with hemolysis,⁷ elevated liver enzymes, and low platelet

⁵ HELLP syndrome, which is an acronym for "hemolysis, elevated liver enzyme values, low platelete [sic] count[.]" is defined as "[a] liver disorder occurring as a complication of pregnancy (usually in the last trimester and in association with eclampsia)." Vol. 5 PR-TG, J.E. Schmidt, M.D., 5 *Attorneys' Dictionary of Medicine* H-49 (Matthew Bender 2010) (hereinafter "*Attorneys' Dictionary of Medicine*").

⁶ "Packed red blood cells" refer to "[r]ed blood cells compacted by centrifuging; a concentrated suspension of red blood cells." *Attorneys' Dictionary of Medicine*, at P-7.

⁷ Hemolysis is defined as "liberation of hemoglobin from red blood cells." Webster's International Dictionary, at 1055.

syndrome complicated by lupus and idiopathic thrombocytopenia purpura (“ITP”).⁸ Dr. Nitsche stopped all additional platelet transfusions at that time based on his belief that they were actually proving to be detrimental to Barbee.

At 12:20 p.m., Dr. Marc Slatkoff, a hematologist employed by Forsyth Medical Center, confirmed Dr. Nitsche’s findings and diagnosed Barbee with “thrombocytopenia in setting of hemolysis, elevated liver enzymes, low platelet syndrome, and lupus failing to improve postpartum.” Dr. Slatkoff notified Dr. Jacobs that Barbee needed further testing to rule out hemolysis and thrombotic thrombocytopenic purpura (TTP).⁹ Dr. Slatkoff ordered a peripheral blood smear and an ADAMTS13 test. Based on the results of the blood smear, he (1) noted “evidence of hemolysis with severe thrombocytopenia[;]” (2) added “Evans Syndrome”¹⁰ to his diagnosis; and (3) “ordered a continuation of steroids, complete blood count, protonix, daily blood smear and additional testing for lactate dehydrogenase”

On the morning of 3 September 2012, Dr. Slatkoff evaluated Barbee and “noted that her blood smear showed increased fragments of red blood cells.” Based on this

⁸ ITP is “[a] disease marked by ecchymoses (small hemorrhagic spots in the skin or mucous membranes), anemia, deficiency in the number of platelets, prostration, etc. It may be fatal.” *Attorneys’ Dictionary of Medicine*, at I-15.

⁹ TTP is “[a] disease of unknown etiology, marked by thrombocytopenia (insufficient number of platelets), hemolytic anemia . . . , fever, and thrombosis (crust formation) in the small arteries and capillaries.” *Attorneys’ Dictionary of Medicine*, at T-117.

¹⁰ Evans’ Syndrome is “[t]he disease acquired hemolytic anemia associated with thrombocytopenia (reduction in number of blood platelets).” *Attorneys’ Dictionary of Medicine*, at E-230.

change in the lab results, he became concerned about the “microangiopathic picture and pregnancy related TTP.” Due to this concern, he ordered a plasma exchange.

Prior to receiving the plasma exchange that morning, Barbee went into cardiac arrest. She was pronounced dead at 11:00 a.m. An autopsy revealed that she died “from complications relating to unresolving severe microangiopathic hemolytic anemia and thrombocytopenia.”

On 9 July 2014, Plaintiffs filed a wrongful death action on behalf of Barbee’s estate against Defendants. In their complaint, they alleged that the Lyndhurst Physicians were negligent and that Defendants were liable for their negligence under the doctrine of *respondeat superior*.

Plaintiffs’ complaint alleged that the Lyndhurst Physicians were negligent in the following respects:

- (a) Defendants negligently and carelessly failed to consult a maternal fetal medicine specialist prior to September 2, 2012;
- (b) Defendants negligently and carelessly failed to consult a hematology specialist prior to September 2, 2012;
- (c) Defendants negligently and carelessly failed to evaluate laboratory values demonstrating the deteriorating condition of Lauren Barbee;
- (d) Defendants negligently and carelessly failed to order a ADAMTS13 test upon admission to the hospital;
- (e) Defendants negligently and carelessly administered blood transfusions that were detrimental to Lauren

Barbee;

(f) Defendants negligently and carelessly diagnosed HELLP Syndrome and continued to treat HELLP Syndrome despite no evidence of elevated liver enzymes and Lauren Barbee's deteriorating condition after the delivery of her child;

(g) Defendants negligently and carelessly failed to diagnose Decedent with TTP; and

(h) Defendants negligently and carelessly failed to timely initiate plasmapheresis.

On 10 July 2015, Plaintiffs designated Dr. Jill Mauldin, an associate professor specializing in obstetrics, and Dr. Andrew Eisenberger, an assistant professor specializing in hematology, as expert witnesses who would provide expert opinions at trial. Dr. Mauldin and Dr. Eisenberger were both designated to testify regarding breach of the applicable standard of care by the Lyndhurst Physicians. In addition, Dr. Eisenberger was designated to testify on the issue of proximate causation. Plaintiffs also identified several other individuals who would testify as fact witnesses, including Dr. Slatkoff and Dr. Nitsche.

During discovery, depositions were taken of Dr. Mauldin, Dr. Eisenberger, and Dr. Slatkoff. Defendants filed a motion for summary judgment on 26 February 2016 pursuant to Rule 56 of the North Carolina Rules of Civil Procedure. In their motion, Defendants asserted that

plaintiff has failed to produce evidence from an expert qualified under Rule 702(b) of the North Carolina Rules of

Evidence and G.S. § 90-21.12, and as required by Rule 9(j) of the North Carolina Rules of Civil Procedure, that [defendants] breached the applicable standard of care. In addition, plaintiff has failed to produce competent evidence from a qualified witness that any alleged negligence by defendants proximately caused any injury or death to [Barbee].

On 17 March 2016, a hearing on Defendants’ motion was held before the Honorable R. Stuart Albright in Forsyth County Superior Court. The following day, the trial court entered an order granting summary judgment in favor of Defendants.

On 21 March 2016, Plaintiffs filed an affidavit of Dr. Mauldin, which sought to expand upon the testimony she had given during her deposition. On 31 March 2016, Plaintiffs filed a “Motion for Reconsideration and to Vacate or Amend Judgment” pursuant to Rules 59(e) and 60 of the North Carolina Rules of Civil Procedure. Defendants filed a motion to strike Dr. Mauldin’s affidavit on 1 April 2016, asserting both that her affidavit was untimely and that it contradicted her prior deposition testimony. A hearing was held before Judge Albright on 9 May 2016 on the parties’ motions. On 13 May 2016, the trial court issued an order denying Plaintiffs’ motion and granting Defendants’ motion to strike Dr. Mauldin’s affidavit. On 10 June 2016, Plaintiffs filed a notice of appeal as to the trial court’s 18 March 2016 and 13 May 2016 orders.

Analysis

I. Appellate Jurisdiction

As an initial matter, we must determine whether we have appellate jurisdiction to hear this appeal. Defendants have filed a motion to dismiss the appeal, contending that Plaintiffs' notice of appeal was untimely.

"It is well established that failure to give timely notice of appeal is jurisdictional, and an untimely attempt to appeal must be dismissed." *In re A.L.*, 166 N.C. App. 276, 277, 601 S.E.2d 538, 538 (2004) (citation, quotation marks, brackets, and ellipsis omitted). Rule 3 of the North Carolina Rules of Appellate Procedure states, in pertinent part, as follows:

(c) Time for Taking Appeal. In civil actions and special proceedings, a party must file and serve a notice of appeal:

(1) within thirty days after entry of judgment if the party has been served with a copy of the judgment within the three day period prescribed by Rule 58 of the Rules of Civil Procedure; or

(2) within thirty days after service upon the party of a copy of the judgment if service was not made within that three day period; provided that

(3) if a timely motion is made by any party for relief under Rules 50(b), 52(b) or 59 of the Rules of Civil Procedure, the thirty day period for taking appeal is tolled as to all parties until entry of an order disposing of the motion and then runs as to each party from the date of entry of the order or its untimely service upon the party, as provided in subdivisions (1) and (2) of this subsection (c).

N.C. R. App. P. 3(c).

Here, the trial court entered an order granting summary judgment in favor of Defendants on 18 March 2016. Plaintiffs then filed a motion for reconsideration and to vacate or amend the judgment pursuant to Rules 59(e) and 60 on 31 March 2016. Thus, Plaintiffs argue, the thirty-day period for taking an appeal was tolled until the trial court entered its 13 May 2016 order denying their motion.

In their motion, Plaintiffs sought “pursuant to Rules 59(e) and 60 of the North Carolina Rules of Civil Procedure . . . reconsideration on the grounds that the [18 March 2016] Order was entered in error, contrary to fact and law, and is otherwise subject to further review and amendment, as set forth herein and as more fully set out at the hearing on this motion.” “Rule 59(e) governs motions to alter or amend a judgment, and such motions are limited to the grounds listed in Rule 59(a).” *N.C. All. for Transp. Reform, Inc. v. N.C. Dep’t of Transp.*, 183 N.C. App. 466, 469, 645 S.E.2d 105, 108 (2007) (citation omitted). Plaintiffs’ motion was apparently brought pursuant to Rule 59(a)(8), which states that a new trial may be granted if there is an “[e]rror in law occurring at the trial and objected to by the party making the motion.” N.C. R. Civ. P. 59(a)(8).

However, Defendants argue that a motion filed pursuant to Rule 59 will only toll the deadline for filing a notice of appeal if the motion is a *proper* Rule 59 motion, *see Smith v. Johnson*, 125 N.C. App. 603, 606, 481 S.E.2d 415, 417 (1997), and that motions made pursuant to Rule 59(a)(8) only apply to errors in law occurring *at trial*,

see Bodie Island Beach Club Ass’n, Inc. v. Wray, 215 N.C. App. 283, 294-95, 716 S.E.2d 67, 77 (2011) (holding that “both Rule 59(a)(8) and (9) are post-trial motions” and did not apply because the “case concluded at the summary judgment stage” (quotation marks and brackets omitted)). Thus, Defendants contend that Plaintiffs’ motion was not a proper motion under Rule 59(a)(8) because the trial court’s 18 March 2016 order occurred at the summary judgment stage. Additionally, they contend that a motion brought pursuant to Rule 60 does not toll the deadline for filing a notice of appeal. *See Parrish v. Cole*, 38 N.C. App. 691, 695, 248 S.E.2d 878, 880 (1978) (“A motion under Rule 60(b) does not toll the time for notice of appeal” (citation omitted)). For these reasons, Defendants assert that Plaintiffs’ motion did not toll their deadline for filing a notice of appeal.

Even assuming *arguendo* that Defendants’ argument is correct, Plaintiffs have filed a petition for writ of *certiorari* pursuant to Rule 21 of the North Carolina Rules of Appellate Procedure seeking our review of the trial court’s order despite the untimeliness of their notice of appeal. “The writ of certiorari may be issued in appropriate circumstances by either appellate court to permit review of the judgments and orders of trial tribunals when the right to prosecute an appeal has been lost by failure to take timely action.” N.C. R. App. P. 21. We conclude that *certiorari* is appropriate in this case. *See Crawford v. Commercial Union Midwest Ins. Co.*, 147 N.C. App. 455, 457 n.2, 556 S.E.2d 30, 32 n.2 (2001) (granting plaintiffs’

petition for writ of *certiorari* despite fact that plaintiffs' appeal was untimely because their motion invoking Rule 59 was not sufficient to toll notice of appeal), *aff'd per curiam*, 356 N.C. 609, 572 S.E.2d 781 (2002). Therefore, we proceed to address the merits of Plaintiffs' arguments.

II. Entry of Summary Judgment in Favor of Defendants

On appeal, Plaintiffs argue that the trial court erred in granting summary judgment in favor of Defendants. "Summary judgment is proper if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that any party is entitled to a judgment as a matter of law[.]" and "[t]he trial court must consider the evidence in the light most favorable to the non-moving party." *Robinson v. Duke Univ. Health Sys., Inc.*, 229 N.C. App. 215, 219, 747 S.E.2d 321, 326 (2013) (internal citations and quotation marks omitted). "We review a trial court's ruling on summary judgment *de novo*." *Id.* (citation omitted).

"In a medical malpractice action, a plaintiff has the burden of showing (1) the applicable standard of care; (2) a breach of such standard of care by the defendant; (3) the injuries suffered by the plaintiff were proximately caused by such breach; and (4) the damages resulting to the plaintiff." *Purvis v. Moses H. Cone Mem'l Hosp. Serv. Corp.*, 175 N.C. App. 474, 477, 624 S.E.2d 380, 383 (2006) (citation and quotation marks omitted).

In this appeal, the parties' arguments focus on Plaintiffs' two primary expert witnesses: Dr. Mauldin and Dr. Eisenberger. Plaintiffs designated Dr. Mauldin as an expert witness to testify regarding the Lyndhurst Physicians' breach of the applicable standard of care. They designated Dr. Eisenberger as an expert witness to testify regarding the issues of both breach of the standard of care and proximate cause.

At the summary judgment stage, Defendants argued that (1) based on their deposition testimony, neither of these two witnesses was qualified to offer expert testimony with regard to the breach of standard of care issue and that — as a result — Plaintiffs had failed to provide enough evidence at the summary judgment stage as to that element of their medical malpractice claim; and (2) Plaintiffs failed to sufficiently forecast evidence showing that any alleged breach of the applicable standard of care by the Lyndhurst Physicians was a proximate cause of Barbee's death.

In its 18 March 2016 order, the trial court did not expressly make a determination as to the admissibility of the expert testimony of Dr. Mauldin or Dr. Eisenberger. Instead, the court simply granted Defendants' motion for summary judgment without stating the grounds for its decision.

On appeal, Plaintiffs contend that (1) both Dr. Mauldin and Dr. Eisenberger were qualified to offer expert testimony regarding breach of the applicable standard

of care by the Lyndhurst Physicians; and (2) the testimony of Dr. Eisenberger and Dr. Slatkoff sufficiently forecasted evidence on the issue of proximate cause. We address each argument in turn.

A. Breach of Standard of Care

We first consider Plaintiffs’ argument that the entry of summary judgment was improper based on Defendants’ contentions that Dr. Mauldin and Dr. Eisenberger were unqualified to provide expert testimony regarding breach of the applicable standard of care. “One of the essential elements of a claim for medical negligence is that the defendant breached the applicable standard of medical care owed to the plaintiff.” *Hawkins v. SSC Hendersonville Operating Co., LLC*, 202 N.C. App. 707, 710, 690 S.E.2d 35, 38 (2010) (citation and quotation marks omitted). “Plaintiffs must establish the relevant standard of care through expert testimony.” *Robinson*, 229 N.C. App. at 234, 747 S.E.2d at 335 (citation omitted).

Ordinarily, “[a] trial court’s ruling on the qualifications of an expert or the admissibility of an expert’s opinion will not be reversed on appeal absent a showing of abuse of discretion.” *N.C. Dep’t of Transp. v. Haywood Cty.*, 360 N.C. 349, 351, 626 S.E.2d 645, 646 (2006) (citation and quotation marks omitted). Under that standard of review, “the trial judge is afforded wide latitude of discretion when making a determination about the admissibility of expert testimony.” *State v. Bullard*, 312 N.C. 129, 140, 322 S.E.2d 370, 376 (1984).

Here, however, because the trial court granted summary judgment in favor of Defendants without explicitly ruling on the admissibility of the expert testimony of Dr. Eisenberger and Dr. Mauldin, we review the trial court's order granting summary judgment *de novo*. See *Robinson*, 229 N.C. App. at 219, 747 S.E.2d at 326 (reviewing *de novo* trial court's summary judgment order where admissibility of expert witness testimony was disputed); *Grantham v. Crawford*, 204 N.C. App. 115, 117, 693 S.E.2d 245, 247 (2010) (reviewing *de novo* entry of summary judgment in case involving question of whether plaintiff's expert witness was qualified).

With regard to Dr. Eisenberger, Defendants asserted that he (1) was not familiar with the community standard of care in Winston-Salem as required under N.C. Gen. Stat. § 90-21.12; and (2) was not qualified under Rule 702(a) of the North Carolina Rules of Evidence, which requires an expert to practice in the same or in a similar specialty as the physician against whom the breach of standard of care testimony is offered. With regard to Dr. Mauldin, Defendants argued she was not qualified under Rule 702(b), which requires expert witnesses to have spent a majority of their time in active clinical practice or in the instruction of students during the year immediately preceding the date of the occurrence that is the basis for the action.

1. Dr. Eisenberger's Testimony

Plaintiffs argue that the trial court could not have properly determined at the summary judgment stage that Dr. Eisenberger was unqualified to testify as an expert witness. During his discovery deposition, Dr. Eisenberger testified that the

Lyndhurst Physicians breached the applicable standard of care by (1) failing to consult a hematologist earlier in time; and (2) ordering platelet transfusions when TTP should have been suspected.

Defendants contend that (1) Dr. Eisenberger lacked the requisite knowledge of the community standard of care in Winston-Salem as required by N.C. Gen. Stat. § 90-21.12; and (2) he did not satisfy the requirements of Rule 702(a) because he lacked a similar specialty as the physicians against whom his testimony was offered. Because we conclude that Dr. Eisenberger's deposition testimony failed to establish that he possessed the requisite knowledge of the applicable community standard of care, we hold that he was not authorized to offer an expert opinion regarding whether the Lyndhurst Physicians breached the standard of care.¹¹

N.C. Gen. Stat. § 90-21.12 provides as follows:

Except as provided in subsection (b) of this section, in any medical malpractice action as defined in G.S. 90-21.11(2)(a), the defendant health care provider shall not be liable for the payment of damages unless the trier of fact finds by the greater weight of the evidence that the care of such health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated *in the same or similar communities* under the same or similar circumstances at the time of the alleged act giving rise to the cause of action; or in the case of a medical malpractice action as defined in G.S. 90-21.11(2)(b), the defendant health care provider shall not be liable for the

¹¹ While Plaintiffs assert that Defendants failed to contest the admissibility of Dr. Eisenberger's testimony on this ground in the trial court, both Defendants' motion for summary judgment and the transcript of the summary judgment hearing belie this contention.

payment of damages unless the trier of fact finds by the greater weight of the evidence that the action or inaction of such health care provider was not in accordance with the standards of practice among similar health care providers situated *in the same or similar communities* under the same or similar circumstances at the time of the alleged act giving rise to the cause of action.

N.C. Gen. Stat. § 90-21.12 (2015) (emphasis added).

“When determining whether an expert is familiar with the standard of care in the community where the injury occurred, a court should consider whether an expert is familiar with a community that is similar to a defendant’s community in regard to physician skill and training, facilities, equipment, funding, and also the physical and financial environment of a particular medical community.” *Billings v. Rosenstein*, 174 N.C. App. 191, 194, 619 S.E.2d 922, 924-25 (2005) (citation and quotation marks omitted). “Our statutes and case law do not require an expert to have actually practiced in the community in which the alleged malpractice occurred, or even to have practiced in a similar community.” *Crocker v. Roethling*, 363 N.C. 140, 151, 675 S.E.2d 625, 633 (2009) (Martin, J., concurring).¹² Moreover, “our law does not prescribe any particular method by which a medical doctor must become familiar with a given community. Book or Internet research may be a perfectly

¹² The Supreme Court’s decision in *Crocker* contained an opinion by Justice Hudson and a concurring opinion by Justice Martin. As stated in Justice Newby’s dissent in *Crocker*, “Justice Martin’s opinion, having the narrower directive, is the controlling opinion . . .” *Crocker*, 363 N.C. at 154 n.1, 675 S.E.2d at 635 n.1 (Newby, J., dissenting) (citation omitted); *see also Grantham*, 204 N.C. App. at 122 n.1, 693 S.E.2d at 250 n.1; *Barringer v. Wake Forest Univ. Baptist Med. Ctr.*, 197 N.C. App. 238, 251 n.4, 677 S.E.2d 465, 474 n.4 (2009).

acceptable method of educating oneself regarding the standard of medical care applicable in a particular community.” *Id.* (citation and quotation marks omitted).

In the present case, Defendants deposed Dr. Eisenberger on 9 October 2015. He testified that he was an assistant professor of clinical medicine at Columbia University and specialized in hematology and oncology. The following exchange occurred during the deposition:

[DEFENDANTS’ COUNSEL:] Do you recall ever being to or ever going to North Carolina, specifically Winston-Salem?

[DR. EISENBERGER:] No.

[DEFENDANTS’ COUNSEL:] You don’t think you have ever been there?

[DR. EISENBERGER:] No.

[DEFENDANTS’ COUNSEL:] Have never been to Forsyth Medical Center, to your knowledge?

[DR. EISENBERGER:] No, I have not.

[DEFENDANTS’ COUNSEL:] Do you know anything about that hospital?

[DR. EISENBERGER:] No.

[DEFENDANTS’ COUNSEL:] Do you know anything about the education, training and experience of the obstetricians who provided care to Lauren Barbee, either prenatally or during the hospital admission?

[DR. EISENBERGER:] I am not sure I understand the question.

[DEFENDANTS' COUNSEL:] Well, there were a number of obstetricians who provided --

[DR. EISENBERGER:] Correct.

[DEFENDANTS' COUNSEL:] -- care for her prenatally and during the hospital?

[DR. EISENBERGER:] Right.

[DEFENDANTS' COUNSEL:] Do you know anything about their experience, their training?

[DR. EISENBERGER:] I mean, their -- no, I do not. I don't know them. I haven't looked them up.

[DEFENDANTS' COUNSEL:] To your knowledge, do you know any physicians who practice in North Carolina?

[DR. EISENBERGER:] I don't believe so.

[DEFENDANTS' COUNSEL:] Any hematologists who work in North Carolina that you have a consulting relationship with or know from some prior position of employment?

[DR. EISENBERGER:] No, I do not.

Our appellate courts have addressed on several occasions the issue of whether a trial court properly granted summary judgment based on an expert witness's inability to satisfy N.C. Gen. Stat. § 90-21.12. *See generally Crocker*, 363 N.C. 140, 675 S.E.2d 625; *Robinson*, 229 N.C. App. 215, 747 S.E.2d 321; *Purvis*, 175 N.C. App.

474, 624 S.E.2d 380; *Smith v. Whitmer*, 159 N.C. App. 192, 582 S.E.2d 669 (2003). It is helpful to examine each of these cases.

In *Smith*, the defendants were a doctor and medical group that had practices in Tarboro and Rocky Mount. The plaintiff's expert witness testified during a discovery deposition that "the sole information he received or reviewed concerning the relevant standard of care in Tarboro or Rocky Mount was verbal information from plaintiff's attorney regarding the approximate size of the community and what goes on there." *Smith*, 159 N.C. App. at 196-97, 582 S.E.2d at 672. He further testified that he had never visited these cities, had never spoken to any health care practitioners in the area, and was not acquainted with the medical community in these cities. *Id.* at 197, 582 S.E.2d at 672. We affirmed the trial court's entry of summary judgment in favor of the defendants, holding that although the expert testified that he was familiar with the applicable standard of care in Tarboro and Rocky Mount "his testimony [was] devoid of support for this assertion." *Id.* at 196, 582 S.E.2d at 672.

In *Purvis*, the plaintiffs' sole expert witness on the standard of care testified during a discovery deposition that he had no personal knowledge of Greensboro, the city in which the defendants' hospital was located. *Purvis*, 175 N.C. App. at 480, 624 S.E.2d at 385. Instead, he relied solely on Internet materials supplied by plaintiffs' counsel, which described the standard of care in that community at the time of the

deposition. *Id.* However, the incident giving rise to the case occurred four years prior to the expert's deposition. Based on the expert witness's lack of knowledge regarding the standard of care in Greensboro at the time of the incident giving rise to the action, the trial court granted summary judgment in favor of the defendants. *Id.*

Because we determined that “[t]he record [did] not contain any indication that the resources available at [the defendants’ hospital] and the standard of care were the same in 1998 as in 2003” and the expert did not show that he was “familiar with the standard of care in the same or similar community at the time of the alleged act giving rise to the cause of action[,]” we affirmed the trial court’s entry of summary judgment. *Id.* at 480, 624 S.E.2d at 385 (quotation marks omitted). In so holding, we stated as follows:

In opposing a motion for summary judgment in a medical malpractice case, a plaintiff must demonstrate that his expert witness is competent to testify as an expert witness to establish the appropriate standard of care in the relevant community. In other words, in order to establish the relevant standard of care for a medical malpractice action, an expert witness must demonstrate that he is familiar with the standard of care in the community where the injury occurred, or the standard of care in similar communities. In the absence of such a showing, summary judgment is properly granted.

Id. at 477-78, 624 S.E.2d at 384 (internal citations, quotation marks, and brackets omitted).

In *Crocker*, an expert witness testified during a discovery deposition that he believed a physician in Phoenix, Arizona would have the “same knowledge” as a physician in Goldsboro, North Carolina regarding obstetrical care and shoulder dystocia. *Crocker*, 363 N.C. at 144, 675 S.E.2d at 629 (quotation marks omitted). He “correctly described the applicable standard of care as that of a reasonably trained physician practicing in the same or similar circumstances.” *Id.* (quotation marks omitted). Prior to the trial court’s hearing on the defendants’ motion for summary judgment, the plaintiffs filed an affidavit from the expert in which he stated that he was familiar with the prevailing standard of care “in the same or similar community to Goldsboro, North Carolina in 2001 by a physician with the same or similar training, education and experience as [the defendant].” *Id.* at 145, 675 S.E.2d at 630. The trial court granted summary judgment in favor of the defendants “after concluding that the testimony of plaintiffs’ sole expert witness should be excluded.” *Id.* at 141, 675 S.E.2d at 628.

On appeal, the Supreme Court determined that the trial court had erred in granting summary judgment for the defendants on this ground. In his concurring opinion that — as noted above — was the controlling opinion for the Court, Justice Martin stated that “[w]hen the proffered expert’s familiarity with the relevant standard of care is unclear from the paper record, our trial courts should consider requiring the production of the expert for purposes of voir dire examination.” *Id.* at

152, 675 S.E.2d at 634 (Martin, J., concurring). He further explained that in “close cases” where “the admissibility decision may be outcome-determinative, the expense of voir dire examination and its possible inconvenience to the parties and the expert are justified in order to ensure a fair and just adjudication.” *Id.* He stated the following regarding this issue:

Voir dire examination provides the trial court with the opportunity to explore the foundation of the expert’s familiarity with the community, the method by which the expert arrived at his conclusion regarding the applicable standard of care, and the link between this method and the expert’s ultimate opinion. Moreover, unlike the nonadversarial discovery process, counsel for both parties may participate equally in a voir dire hearing and help elicit all information relevant to the expert’s qualifications and the admissibility of the proposed testimony.

Perhaps most importantly, voir dire examination provides the trial court with an informed basis to guide the exercise of its discretion. It is precisely because the trial court has the advantage of seeing and hearing the witnesses that the trial court’s discretionary decision is entitled to deference on appeal.

Id. at 152-53, 675 S.E.2d at 634 (internal citations and quotation marks omitted).

Thus, the Court remanded the case to the trial court with instructions to conduct a voir dire examination of the expert witness to determine the admissibility of his proposed testimony. *Id.* at 153, 675 S.E.2d at 635.

In *Robinson*, we applied the Supreme Court’s decision in *Crocker*, summarizing the pertinent facts of the case as follows:

Dr. Braveman [the expert witness] testified during

his deposition that he knew nothing about Dr. Mantyh's [defendant's] education, training, or experience at that time. Dr. Braveman testified that he had never visited Duke University Health System [the defendant's hospital] or any of its facilities and knew nothing about their surgical facilities. Dr. Braveman stated that he had not reviewed the website or read any materials about Duke. Dr. Braveman stated that all he knew about Duke was that it had "a great reputation." Dr. Braveman stated that he knew Duke was "a tertiary care facility and takes care of all aspects of medical problems." Dr. Braveman stated that the only information he had about Duke was that "it's a university health system and it's got a national reputation[.]" Dr. Braveman further testified that he believed there existed a national standard of care with respect to colorectal surgeons and that the standard of care prevalent at Duke University "should not be different" from the standard of care prevalent at the three medical centers with which he was familiar.

Subsequent to his deposition, Dr. Braveman submitted an affidavit stating that he was "familiar with the standard of care for physicians such as Dr. Mantyh practicing in Durham, North Carolina, the Research Triangle area, and similar communities such as Worcester, Massachusetts[;] Cleveland, Ohio[;] and Columbus, Ohio in 2008 with respect to the type of procedure Dr. Mantyh performed on Linda Robinson on or about March 12, 2008." Dr. Braveman further stated in his affidavit that "[a]t the time of [his] testimony, [he] had specific familiarity with the standard of care in the three communities in which [he had] practiced and was of the opinion then that the standard of care was similar across those communities and Durham, North Carolina." Dr. Braveman's affidavit explained that since giving his deposition testimony, "[he had] confirmed [his] opinion with Internet research regarding Duke University Hospital and [had] confirmed that it is a sophisticated training hospital such as the other ones with which [he had] personal familiarity."

Robinson, 229 N.C. App. at 234-35, 747 S.E.2d at 335.

On appeal, the defendants argued that the expert’s affidavit impermissibly contradicted his prior deposition testimony. We disagreed, holding that “rather than contradicting his testimony, [the] affidavit actually supplements it.” *Id.* at 236, 747 S.E.2d at 336. We ruled that the expert’s affidavit “reaffirms his belief that the applicable standard of care is similar to that of the medical facilities with which he was familiar and that he had confirmed his beliefs through Internet research.” *Id.* Relying upon *Crocker*, we held that the expert’s testimony “[c]onsidered as a whole . . . satisfied the requirements of N.C. Gen. Stat. § 90-21.12.” *Id.*

In the present case, the summary judgment record was devoid of *any* evidence that Dr. Eisenberger possessed knowledge of the applicable standard of care in Winston-Salem or a similar community. Moreover, unlike the expert witnesses in *Crocker* and *Robinson*, Plaintiffs did not submit an affidavit from him prior to the trial court’s summary judgment order supplementing his deposition testimony and demonstrating that he did, in fact, possess knowledge of the applicable standard of care in Winston-Salem during the relevant time period. Instead, Dr. Eisenberger is more akin to the expert witnesses in *Smith* and *Purvis* whose testimony showed that they lacked sufficient knowledge regarding the relevant community standard of care.

Plaintiffs’ argument that Dr. Eisenberger’s deposition testimony was merely “undeveloped” is not supported by North Carolina caselaw. Our courts have made clear that in a medical malpractice case, the plaintiff is required to demonstrate at

the summary judgment stage that its expert witnesses are qualified to offer expert testimony in accordance with the Rules of Evidence and applicable statutory requirements. *See, e.g., Purvis*, 175 N.C. App. at 477-78, 624 S.E.2d at 384. Thus, because Plaintiffs failed to make a showing at the summary judgment stage that Dr. Eisenberger met the requirements of N.C. Gen. Stat. § 90-21.12, his testimony regarding the Lyndhurst Physicians' breach of the standard of care could not have been properly considered by the trial court in ruling on Defendants' motion for summary judgment.¹³

2. Dr. Mauldin's Testimony

We next address Plaintiffs' argument that Dr. Mauldin was qualified to offer expert testimony in this case. During her discovery deposition, Dr. Mauldin testified that the Lyndhurst Physicians breached the applicable standard of care by not consulting an MFM physician and a hematologist prior to the delivery of Barbee's baby or within 36 hours after delivery.

In their summary judgment motion, Defendants contended that Dr. Mauldin's deposition testimony demonstrated her lack of qualifications to offer an opinion on this issue in light of her inability to satisfy the requirements of Rule 702(b). Rule 702(b) states, in pertinent part, as follows:

(2) *During the year immediately preceding the date of the*

¹³ Because of our ruling that Dr. Eisenberger's testimony on this subject was inadmissible based on N.C. Gen. Stat. § 90-21.12, we need not address Defendants' additional argument under Rule 702(a).

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occurrence that is the basis for the action, the expert witness must have devoted a *majority* of his or her professional time to either or both of the following:

- a. The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered, and if that party is a specialist, the active clinical practice of the same specialty or a similar specialty which includes within its specialty the performance of the procedure that is the subject of the complaint and have prior experience treating similar patients; or
- b. The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered, and if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

N.C. R. Evid. 702(b)(2) (emphasis added).

Defendants assert that because Dr. Mauldin testified 50% of her work was administrative, she cannot show that a “majority” of her time was spent either in active clinical practice or instructing students between August 2011 and August 2012 as required by Rule 702(b). *See Cornett v. Watauga Surgical Grp., P.A.*, 194 N.C. App. 490, 495, 669 S.E.2d 805, 808 (2008) (holding that expert witness “did not meet the requirements of Rule 702(b) since, in a sixty-hour work week, at the most, [he] spent five hours a week in clinical surgery and instructing surgery [and t]his was less than half of his professional time”).

In her deposition, Dr. Mauldin testified that she had worked as an associate professor at the OB/GYN Department at the Medical University of South Carolina (“MUSC”) from 1998 to July 2015. Starting in 2008, she “assume[d] the position of medical director of the women’s care line” and testified about this position, in pertinent part, as follows:

[DEFENDANTS’ COUNSEL:] What did you do for the remainder of your time? Let’s say, when you’re not assigned to labor and delivery, what did your practice consist of?

[DR. MAULDIN:] *So about 50 percent of my time was administrative.* I was the medical director for women’s health for MUSC Hospital. And so if I wasn’t doing administrative work, then, clinically, I was performing MFM clinical duties.

Sometimes that was labor and delivery coverage. About one week every two months it was covering the antepartum service, just managing the people who were hospitalized. And other than that, then I would be in the MFM clinic seeing patients and doing ultrasounds, prenatal diagnosis.

[DEFENDANTS’ COUNSEL:] Okay. So you said that you were medical director of what?

[DR. MAULDIN:] Women’s -- it’s called the women’s service line. But, basically, it was like women’s services for the hospital.

[DEFENDANTS’ COUNSEL:] And it’s listed here women’s care service line.

[DR. MAULDIN:] Yes.

. . . .

[DR. MAULDIN:] It really -- this hospital, several years ago, or eight or nine years ago, had divided the hospital clinical care systems up into about nine service lines. So we had like a women's health or women's care service line, a pediatric service line, an orthopedic service line, and those sort of things. So I just managed all of the women's health in conjunction, then, with the department, you know, which had its own department chair.

. . . .

[DEFENDANTS' COUNSEL:] Help me understand, then, what you would do as medical director of women's services as opposed to the department and division heads of OB/GYN and MFM and those kind of things.

[DR. MAULDIN:] Uh-huh. And a large part of my time was focusing on quality improvement, so working with the nurses to establish quality improvement processes and taking that back to the department to make sure that the physicians or that the faculty in the department understood what needed to be done, how they needed to work together.

It -- so it was quality improvement. It was, you know, focusing on the metrics that the accreditation agencies are now working with a lot of hospitals to do.

You know, so -- you know, ensuring that our data was entered correctly, you know, whether that meant going back to the faculty and ensuring that they were charting correctly so our documentation would come out right and our numbers would come out right.

. . . .

[DR. MAULDIN:] It was hit or miss, random. So I -- you know, I had to request -- you know, I usually had requested, you know, with some standing meetings not to work, you know, certain afternoons. We did a lot of juggling of the schedule to make sure that I could be there.

Over the past six months, a lot of the time was spent planning a new women's hospital.

[DEFENDANTS' COUNSEL:] *So 50 percent of your time was administrative*, devoted to those endeavors; correct?

[DR. MAULDIN:] Correct.

[DEFENDANTS' COUNSEL:] We talked about your coverage of labor and delivery.

[DR. MAULDIN:] Correct.

[DEFENDANTS' COUNSEL:] And then we had this other category, I guess, that would be true maternal-fetal medicine; correct?

[DR. MAULDIN:] Correct.

[DEFENDANTS' COUNSEL:] You made reference to a clinic. So would patients be seen in an office setting in a clinic?

[DR. MAULDIN:] Correct.

. . . .

[DEFENDANTS' COUNSEL:] All right. So if I have the administrative, the MFM clinic and work, and the labor and delivery assignments, is there any portion missing to your practice?

[DR. MAULDIN:] That is it.

Plaintiffs respond to Defendants' argument by asserting that Dr. Mauldin never actually testified that 50% of her work was administrative during the year preceding the date of the occurrence that is the basis for the action, which is the

relevant time period for purposes of Rule 702(b). Instead, they contend, during the above-quoted portions of her testimony Dr. Mauldin was referring solely to the six-month period immediately prior to the deposition or, alternatively, that she was referencing her entire seven years as medical director of the women's care line.

Based upon our reading of Dr. Mauldin's deposition, we find her testimony ambiguous on the issue of whether she was able to satisfy Rule 702(b). Plaintiffs are correct that Dr. Mauldin was never expressly asked during the deposition to quantify the amount of time she spent performing administrative work between August 2011 and August 2012 — the relevant time period under Rule 702(b).

However, in the course of her testimony Dr. Mauldin did not affirmatively testify that a majority of her time during the key period was spent in clinical practice or instructing students as required by Rule 702(b). In apparent recognition of this fact, Plaintiffs submitted an affidavit from Dr. Mauldin clarifying that she did, in fact, spend a majority of her time between August 2011 and August 2012 in active clinical practice or instructing students. However, unlike in *Crocker* and *Robinson*, Dr. Mauldin's affidavit was not filed until *after* the trial court had already granted summary judgment for Defendants.

In its 13 May 2016 order denying Plaintiffs' motion under Rules 59 and 60, the trial court expressly struck Dr. Mauldin's affidavit as untimely. In their appellate briefs, Plaintiffs make no argument that the trial court's striking of her affidavit

constituted error. Indeed, although Plaintiffs’ notice of appeal stated that Plaintiffs were appealing both the trial court’s 18 March 2016 summary judgment order *and* its 13 May 2016 order, Plaintiffs’ brief only contains arguments relating to the 18 March 2016 order. Therefore, Plaintiffs have waived any arguments relating to the trial court’s 13 May 2016 order. *See* N.C. R. App. P. 28(b)(6) (“Issues not presented in a party’s brief, or in support of which no reason or argument is stated, will be taken as abandoned.”).

However, even assuming, without deciding, that Dr. Mauldin’s deposition testimony — standing alone — presents the sort of “close case” contemplated in *Crocker* that would normally require a remand to the trial court for a *voir dire* examination, we conclude that such a remand would be pointless. This is so because, as discussed below, even taking into account Dr. Mauldin’s opinion testimony at her deposition Plaintiffs did not forecast sufficient evidence of proximate causation to withstand Defendants’ motion for summary judgment.

B. Proximate Cause

It is well settled that “[i]n order to survive a motion for summary judgment, a plaintiff must offer evidence of each essential element of negligence beyond mere speculation or conjecture.” *Anderson v. Hous. Auth. of City of Raleigh*, 169 N.C. App. 167, 171, 609 S.E.2d 426, 428 (2005) (citation omitted). “In a medical malpractice action, plaintiff must demonstrate by the testimony of a qualified expert that the

treatment administered by the defendant was in negligent violation of the accepted standard of medical care in the community *and that defendant's treatment proximately caused the injury.*" *Huffman v. Inglefield*, 148 N.C. App. 178, 182, 557 S.E.2d 169, 172 (2001) (citation and quotation marks omitted and emphasis added).

North Carolina appellate courts define proximate cause as a cause which in natural and continuous sequence, unbroken by any new and independent cause, produced the plaintiff's injuries, and without which the injuries would not have occurred, and one from which a person of ordinary prudence could have reasonably foreseen that such a result, or consequences of a generally injurious nature, was probable under all the facts as they existed.

Williamson v. Liptzin, 141 N.C. App. 1, 10, 539 S.E.2d 313, 319 (2000) (citation omitted).

"Even where a plaintiff has introduced some evidence of a causal connection between the defendant's failure to diagnose or intervene sooner and the plaintiff's poor ultimate medical outcome, our Court has held that such evidence is insufficient if it merely speculates that a causal connection is possible." *Lord v. Beerman*, 191 N.C. App. 290, 295, 664 S.E.2d 331, 335 (2008). Thus, "[t]he connection or causation between the negligence and death must be probable, not merely a remote possibility." *White v. Hunsinger*, 88 N.C. App. 382, 387, 363 S.E.2d 203, 206 (1988) (citation omitted).

Plaintiffs argue that the testimony of Dr. Mauldin and Dr. Eisenberger combined with the testimony of Dr. Slatkoff was sufficient "to raise a triable issue

regarding proximate causation.” However, as discussed above, Plaintiffs are not able to rely on Dr. Eisenberger’s testimony regarding a breach of the standard of care by the Lyndhurst Physicians based on his failure to satisfy N.C. Gen. Stat. § 90-21.12. For the following reasons, we conclude that Dr. Mauldin’s testimony regarding the breach of the standard of care — even if admissible under Rule 702(b) — did not preclude the entry of summary judgment for Defendants when considered in conjunction with the proximate cause testimony of Dr. Eisenberger¹⁴ and Dr. Slatkoff.

Dr. Mauldin testified that the Lyndhurst Physicians had breached the standard of care by not consulting an MFM physician and a hematologist either on 29 August 2012 (prior to inducing labor) or by 31 August 2012 (36 hours after delivery) given Barbee’s symptoms. In her deposition, Dr. Mauldin testified, in pertinent part, as follows on this issue:

[DEFENDANTS’ COUNSEL:] So when do you intend to opine that MFM and hematology consults should have been simultaneously obtained?

[DR. MAULDIN:] *You know, I think -- I think it would have been ideal to be obtained, if not on the 28th, then on the 29th, that morning after they had received a number of the labs, you know. And then another key point would have been at that 36-hour mark after delivery. You know, because the platelets really had not changed at all after 24 to 36 hours and that is -- and that is just not typical. I*

¹⁴ Our ruling that Dr. Eisenberger was not qualified to render an opinion as to the breach of standard of care issue pursuant to N.C. Gen. Stat. § 90-21.12 does not automatically mean that he was likewise precluded from offering expert testimony on the issue of proximate cause. Defendants have not challenged his qualifications to provide expert testimony on the latter issue, and we therefore assume he was qualified to offer an opinion on that issue.

mean, they may not have been up to normal by 36 hours, but they shouldn't still be 12,000.

[DEFENDANTS' COUNSEL:] All right. Now, I would prefer not to talk about ideal care; okay? I want to know the breach of the standard-of-care opinions that you hold. So are you going to testify in this case that a hematology and an MFM consultation should have been obtained on August 28th, when the patient was admitted?

[DR. MAULDIN:] *I'm going to say that it should have been obtained on the 29th, prior to delivery.*

. . . .

[DEFENDANTS' COUNSEL:] All right. Going back to your standard of care opinions. Remember, my objective was to know what you're going to say when I leave here today.

As we've sort of talked about, the first one was obtaining consultations on the 29th and, also, working her up for lupus; correct?

[DR. MAULDIN:] *Correct.*

[DEFENDANTS' COUNSEL:] All right. *The second one was getting consultations at 36 hours post-delivery since it hadn't been done before --*

[DR. MAULDIN:] *Correct.*

[DEFENDANTS' COUNSEL:] *-- in the absence of signs of improvement; correct?*

[DR. MAULDIN:] *Correct.*

[DEFENDANTS' COUNSEL:] Is there anything additional? Anything beyond that that you plan to say was done incorrectly or constitutes a breach of the standard of care?

[DR. MAULDIN:] No.

(Emphasis added.)

Thus, based on Dr. Mauldin's testimony on the breach of standard of care issue, Plaintiffs were required to provide a forecast of evidence that the Lyndhurst Physicians' failure to obtain these consultations proximately caused Barbee's death. In arguing that there was, in fact, a sufficient forecast of proximate cause, Plaintiffs rely upon the following testimony from Dr. Eisenberger regarding the platelet transfusions administered by the Lyndhurst Physicians:

[PLAINTIFFS' COUNSEL:] Do you have an opinion as to whether or not the platelet transfusions affected Lauren Barbee in any way?

[DR. EISENBERGER:] *I believe that the platelet transfusions that she received accelerated the thrombotic process.*

[PLAINTIFFS' COUNSEL:] Do you have an opinion whether the platelet transfusions ordered by the physicians at Lyndhurst substantially contributed to the death of Lauren Barbee?

. . . .

[DR. EISENBERGER:] *I believe that the platelet transfusions given contributed to her death.*

(Emphasis added.)

Plaintiffs contend that this portion of Dr. Eisenberger's testimony was sufficient to show that the administration of platelets was the proximate cause of

Barbee's death. However, Dr. Mauldin did not testify that the administration of platelets by Defendants was a breach of the standard of care. Instead, as noted above, her breach of standard of care testimony was limited to the Lyndhurst Physicians' failure to consult an MFM physician and a hematologist earlier in their treatment of Barbee. Thus, the key question is whether Plaintiffs provided a forecast of evidence sufficiently *linking* Dr. Mauldin's breach of standard of care testimony (regarding the failure to conduct an earlier consultation with an MFM physician and hematologist) to Dr. Eisenberger's proximate cause testimony that the administration of platelet transfusions proximately caused Barbee's death. Based upon our careful review of the record, we are unable to conclude that any such evidence was offered.

Dr. Slatkoff testified that ordinarily he would not order platelet transfusions for a patient he had diagnosed with TTP. However, he also stated that if a patient had TTP but was bleeding and had a low platelet count, he "might give platelets." He testified that at the time of his 2 September 2012 consultation he had not diagnosed TTP as the cause of Barbee's symptoms.

Dr. Slatkoff further testified that his course of action would not have changed if Barbee's symptoms and blood smear results on 29 August 2012 had been similar to those he observed on 2 September 2012, stating as follows:

[DEFENDANTS' COUNSEL:] Okay. Is it likely, Dr. Slatkoff, given the status of the lab in 2012 that the ADAMTS test result would not have been back by September 3rd even if ordered on August 29th?

[DR. SLATKOFF:] That is likely.

[DEFENDANTS' COUNSEL:] Okay. Do you have [sic] following up on a question you were asked, do you have any reason to think that a blood smear from August 29th would have been any different than the one you saw on September 2nd?

[DR. SLATKOFF:] I don't think I can say.

Plaintiffs offered no testimony from Dr. Slatkoff suggesting that if he had been consulted prior to delivery or within 36 hours of delivery he would have stopped all platelet transfusions. Thus, at most, his testimony suggests that unless Barbee was bleeding and had a low platelet count he would not have ordered platelet transfusions after diagnosing her with TTP.

However, Dr. Slatkoff never testified that he would have diagnosed Barbee with TTP had he been consulted earlier in time. Instead, he testified that he did not have concerns about TTP until his second consultation on 3 September 2012. Thus, Dr. Slatkoff's testimony regarding the actions he ordinarily takes when a patient is diagnosed with TTP cannot suffice to show that he would not have ordered a platelet transfusion for Barbee because Plaintiffs failed to show that Barbee was diagnosed with TTP either prior to or within 36 hours of delivery.

When asked about Dr. Slatkoff's testimony regarding his initial consultation on 2 September 2012, Dr. Eisenberger testified as follows:

[DEFENDANTS' COUNSEL:] Given your review of

Dr. Slatkoff's notes and testimony, are you able to state to a reasonable degree of medical certainty that consulting a hematologist in this case earlier, if it would have been Dr. Slatkoff, would have changed the outcome?

[PLAINTIFFS' COUNSEL]: Object to the form.

[DR. EISENBERGER]: Consulting a hematologist earlier in this case would have -- should have given a different outcome.

. . . .

[DEFENDANTS' COUNSEL:] So I am trying to figure out, given his testimony, how you can say that consulting a hematologist earlier would have changed the outcome in this case if he would have done the same on August 29th as he did on September 2nd--

. . . .

[DR. EISENBERGER]: Consulting him would not have changed the outcome. Changing a -- consulting a different hematologist would have changed -- *could have changed the outcome*.

. . . .

[DEFENDANTS' COUNSEL:] If it had been Dr. Slatkoff, do you agree with me that consulting him earlier in all likelihood would not have changed the outcome for this patient?

[PLAINTIFFS' COUNSEL]: Object to the form.

[DR. EISENBERGER]: I disagree because you -- hindsight is different, and he *may have* at the time on August 29th, he -- when considering the diagnosis of TTP in his differential diagnosis, he *may have* said, please do not transfuse platelets or please be more careful giving

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platelets, which is what he said in his note, and I don't know why he said that on his note because he doesn't give a reason for that in his note on September 2nd.

. . . .

[DEFENDANTS' COUNSEL:] All right. And did you state earlier a few questions ago that you do not think that consulting Dr. Slatkoff earlier would have changed the outcome of this case?

. . . .

[DR. EISENBERGER:] *I don't know what would have happened if you consulted earlier.*

(Emphasis added.)

Our Supreme Court has “found ‘could’ or ‘might’ expert testimony insufficient to support a causal connection when there is additional evidence or testimony showing the expert’s opinion to be a guess or mere speculation.” *Young v. Hickory Bus. Furniture*, 353 N.C. 227, 233, 538 S.E.2d 912, 916 (2000) (citation omitted). Here, Dr. Eisenberger’s testimony on this issue failed to rise beyond mere speculation. Instead, his testimony simply establishes that an earlier consultation with a hematologist *may* have resulted in a cessation of platelet transfusions.

Under well-established caselaw, such speculation is insufficient to satisfy Plaintiffs’ burden of forecasting evidence of proximate cause so as to defeat the entry of summary judgment. *See Campbell v. Duke Univ. Health Sys., Inc.*, 203 N.C. App. 37, 45, 691 S.E.2d 31, 36-37 (2010) (summary judgment properly granted due to

insufficient evidence of proximate causation where expert was “unable to point to any specific incident or action of any defendant during plaintiff’s . . . surgery that would have caused plaintiff’s injuries”); *Azar v. Presbyterian Hosp.*, 191 N.C. App. 367, 371, 663 S.E.2d 450, 453 (2008) (trial court properly granted summary judgment in medical malpractice case where expert’s testimony could not serve as basis for proximate cause given that he merely testified that decedent’s “cardiac condition definitely may have contributed to her death”); *White*, 88 N.C. App. at 386, 363 S.E.2d at 206 (summary judgment properly granted where expert’s testimony that “had [decedent] been transferred to a neurosurgeon earlier . . . his chances of survival would have been increased” failed to forecast sufficient evidence of proximate causation). Accordingly, the trial court did not err in granting Defendants’ motion for summary judgment.

Conclusion

For the reasons stated above, we affirm the trial court’s 18 March 2016 and 13 May 2016 orders.

AFFIRMED.

Judges BRYANT and STROUD concur.

Report per Rule 30(e).